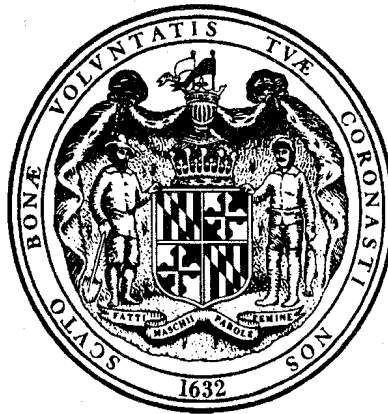


Performance Audit Report

Medicaid Waiver Programs Home and Community-Based Services for Adults with Physical Disabilities and Older Adults

Opportunities Exist to Improve the Cost Efficiency of Service Delivery and to
Enhance Accountability and Fiscal Controls

May 2004



Office of Legislative Audits
Department of Legislative Services
Maryland General Assembly

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Karl S. Aro
Executive Director

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

Bruce A. Myers, CPA
Legislative Auditor

May 26, 2004

Senator Nathaniel J. McFadden, Co-Chair, Joint Audit Committee
Delegate Van T. Mitchell, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We conducted a performance audit on two of the Maryland Medicaid Waiver Programs: the Home and Community-Based Services Waiver for Adults with Physical Disabilities, administered by the Department of Human Resources (DHR); and the Home and Community-Based Services Waiver for Older Adults, administered by the Department of Aging (DOA). The initial basis for this audit was a complaint received on our fraud hotline of allegations of impropriety regarding DHR's operation of its waiver program. On November 21, 2003, we issued a special report that contained findings related to these allegations. This report includes those initial findings, as well as additional findings from the comprehensive audit of the programs.

The goal of these programs is to provide services to participants that would allow them to remain at home or in community-based housing rather than be placed in nursing facilities. The Department of Health and Mental Hygiene (DHMH), which is responsible for the Medicaid Program in Maryland, has entered into memorandums of understanding with DHR and DOA to administer these Medicaid waiver programs, which generally are jointly funded by the State and Federal governments. During fiscal year 2003, a combined \$53 million was spent on case management services, services for recipients (such as attendant care), and other related services for both Medicaid waiver programs.

Our audit disclosed that, for both waiver programs, there were opportunities to improve the cost efficiency of service delivery and to enhance accountability and fiscal controls. We found that DHR paid \$264,700 to case managers for individuals who were not receiving waiver services. This practice contributed to the need for DHR to obtain additional funding, over original cost estimates, without evidence of an increase in waiver services provided to waiver recipients. In addition, we noted an opportunity for coordination of services that could reduce costs with no reduction in monitoring oversight. Specifically, we found that

DHMH, DHR, and DOA each paid different providers to monitor the same recipients who participated in both the State Medicaid program and a waiver program. Furthermore, for both waiver programs, there were inadequate processes to verify the propriety of certain billings, and periodic provider audits were not conducted.

We also noted that DHR and DOA did not effectively monitor the delivery of services or ensure the “cost neutrality” of participant care. “Cost neutrality,” a key requirement for waiver participation, means that the costs of home and community-based services cannot exceed the cost of a nursing facility. Furthermore, initial eligibility determinations and required annual redeterminations (to verify continued eligibility to participate) were not performed or completed timely. Also, required criminal background checks had not been submitted for all personal care aides currently providing services to recipients of the Waiver for Older Adults.

The responses from DHMH, DHR, and DOA are included as an appendix to this report. An executive summary can be found on page 5 of the report. Our audit scope, objectives, and methodology are explained in detail on page 15.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

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Executive Summary

Background

We conducted a performance audit to assess recipient eligibility and claims payment processes for two Medicaid home and community-based services waiver programs: Adults with Physical Disabilities, and Older Adults. The primary goal of these programs is to serve individuals in the community who would otherwise require nursing facility care. The Department of Health and Mental Hygiene (DHMH) has delegated daily administrative responsibility for the Adults with Physical Disabilities Waiver Program to the Department of Human Resources (DHR) and, for the Older Adults Waiver Program, to the Department of Aging (DOA).

Both programs were funded, under their current design, beginning in calendar year 2001. DHR's and DOA's waiver budgets primarily consist of funds to pay for services provided in recipient homes, or in assisted living facilities, as well as administrative expenses for case management. Services provided to Medicaid waiver recipients are generally funded equally with Federal and State general funds. As of June 30, 2003, services were being provided to 375 recipients through the Adults with Physical Disabilities Waiver Program, and to 3,135 recipients through the Older Adults Waiver Program. In fiscal year 2003, approximately \$12.6 million and \$40.5 million were spent for the Adults with Physical Disabilities and Older Adults Waiver Programs, respectively.

The initial basis for this audit was a complaint received on our fraud hotline of allegations of impropriety regarding DHR's operation of its waiver program. On November 21, 2003, we issued a special report that contained findings related to these allegations. This report includes those initial findings, as well as additional findings from the comprehensive audit of both programs. Because of additional information provided by DHR subsequent to the issuance of our initial report, some of the details of those findings, as presented in this report, differ from the initial report.

Conclusions

Our audit raises concerns about the effective administration of both home and community-based services waiver programs. Common to both programs was a lack of effective monitoring of the services provided. Furthermore, neither program effectively monitored "cost neutrality," meaning that there was no assurance that the overall costs of home and community-based services did not exceed the costs of providing nursing facility level of care. Furthermore, procedures were not adequate to ensure that payments were made for authorized

services that had actually been provided. At least in part because of these issues, certain expected program costs were significantly exceeded for the Adults with Physical Disabilities Waiver Program during fiscal years 2002 and 2003. Waiver funding may continue to be insufficient for increased program participation unless more stringent regulations, controls, and procedures are instituted and enforced. We believe that DHMH, as the single State Medicaid agency responsible for waiver funds, should increase its oversight to ensure the efficient and effective use of funds for the waiver programs. Depending on the success in establishing adequate fiscal processes and controls to maximize the use of and safeguarding available State funding, such oversight could ultimately lead to DHMH assuming more direct control over the daily operations of the programs.

Objective 1 – Propriety and Validity of Waiver Service Claims

Our audit disclosed that procedures in place were insufficient to ensure that provider billings paid were properly authorized and were for valid recipients. The primary causes appeared to be ineffective procedures to monitor “cost neutrality” and service utilization, as well as managements’ administrative decisions affecting waiver fiscal operations. For example, we noted that case management fees had been paid by DHR from waiver funds for applicants (that is, individuals not enrolled in the program) who were not receiving waiver services.

In addition, we noted an opportunity for coordination of services that could have a significant financial benefit, but that had not been pursued by DHMH, DHR, or DOA. Specifically, on a monthly basis, DHMH and either DHR or DOA each paid different providers to monitor the same recipients, who participated in both the State Medicaid program (under DHMH) and a waiver program.

Furthermore, for both waiver programs, we noted numerous claims paid without adequate documentation to support that services were actually provided. All the claims issues have potential financial impact, and appropriate corrective action should result in cost savings.

Objective 2 – Propriety and Timeliness of Waiver Eligibility Determinations

Problems were noted with respect to the eligibility determination processes for both waiver programs. These findings included the failure to determine initial eligibility in a timely manner, the failure to adequately document those eligibility determinations, and for certain recipients already in a program, the failure to redetermine eligibility status in a timely manner. Collectively, these weaknesses in the eligibility process could result in ineligible individuals receiving waiver services, or delaying service delivery to appropriate individuals.

Other Significant Issues Noted

During the course of our audit, other issues came to our attention at DHMH and DOA, beyond the objectives of the audit, that warrant mentioning in this report. For the Older Adults Waiver Program, we noted that criminal background checks were not consistently obtained for all participating providers, and that appropriate complaint resolution procedures were not in place. We identified recipient complaints that had not been sufficiently investigated or appropriately resolved. With respect to the Adults with Physical Disabilities Waiver Program, we noted that DHMH had not conducted reviews to monitor the quality of care provided to the recipients, as required by the DHR Quality Assurance Plan.

Recommendations

Although DHR and DOA operate the respective waivers, DHMH retains ultimate responsibility for the Medicaid program in Maryland. It is essential that DHMH take the lead in ensuring appropriate corrective action is taken by both agencies. Specifically, we recommend that the administrative responsibilities for each waiver program be evaluated, and that appropriate payment procedures be established to ensure the efficient and effective use of State resources. Also, we recommend that an effective process be developed for ensuring that provider claims are only paid for appropriate and authorized services, in accordance with regulatory requirements. In addition, all opportunities for cost recovery or savings should be vigorously pursued so that services can be provided to the maximum number of recipients authorized under the waiver programs. We further recommend that eligibility determinations be completed and documented in a timely manner, in accordance with State regulations. Finally, DOA must ensure that criminal background checks are obtained for personal care providers and formal complaint procedures must be established, and DHMH must monitor the quality of care for recipients of the Waiver for Adults with Physical Disabilities Program.

Background Information

Home and Community-Based Services Waiver Programs

The State's Department of Health and Mental Hygiene (DHMH) is responsible for administering the Medicaid program in Maryland. The Federal Social Security Act gives states the option of requesting waivers of certain Federal requirements so that they can develop community-based alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities, or institutions (as would normally be required by Federal regulations).

DHMH and the Department of Human Resources (DHR) implemented the Adults with Physical Disabilities Waiver Program on April 1, 2001. The targeted population for this program includes adults with physical disabilities, between the ages of 21 and 59, who live at home. Once enrolled, participants may remain in this program through age 64.

In 1993, DHMH and the Maryland Department of Aging (DOA) implemented the Senior Assisted Housing Waiver, which preceded the Waiver for Older Adults Program. The targeted population for this original waiver was adults, who were at least 62 years old, and who lived in a community-based setting, rather than in a nursing facility. This waiver program was later expanded to serve adults who are at least 50 years old, and to cover services in all types of licensed assisted living facilities as well as supportive services for individuals living at home. The expanded program was renamed the Waiver for Older Adults, and was approved by the Federal government to begin July 1, 2001.

Cost Neutrality

Under the Federally-approved waivers, states may exclude from waiver participation those individuals for whom there is a reasonable expectation that home and community-based services would be more costly than the Medicaid services the individual would otherwise receive in a nursing facility. According to the Federally-approved waivers for both programs, the cost of care for each program must be "cost neutral," meaning that the overall program costs cannot exceed the average costs for providing Medicaid services in a nursing facility. The Medicaid average annual nursing facility cost of care, as calculated by DHMH, was \$49,695 for fiscal year 2003. Administrative expenses (including case management) are not considered when determining "cost neutrality."

The Waiver for the Adults with Physical Disabilities Program also provides that, as long as the waiver's overall program cost is neutral, with special approval from DHR, the cost of care for an individual recipient in this waiver program may be equal to or less than 115 percent of Medicaid nursing facility costs (\$57,149). The

State regulations applicable to the Waiver for Older Adults Waiver Program more specifically require that *each* recipient's annual cost of care be "cost neutral."

Eligibility Requirements

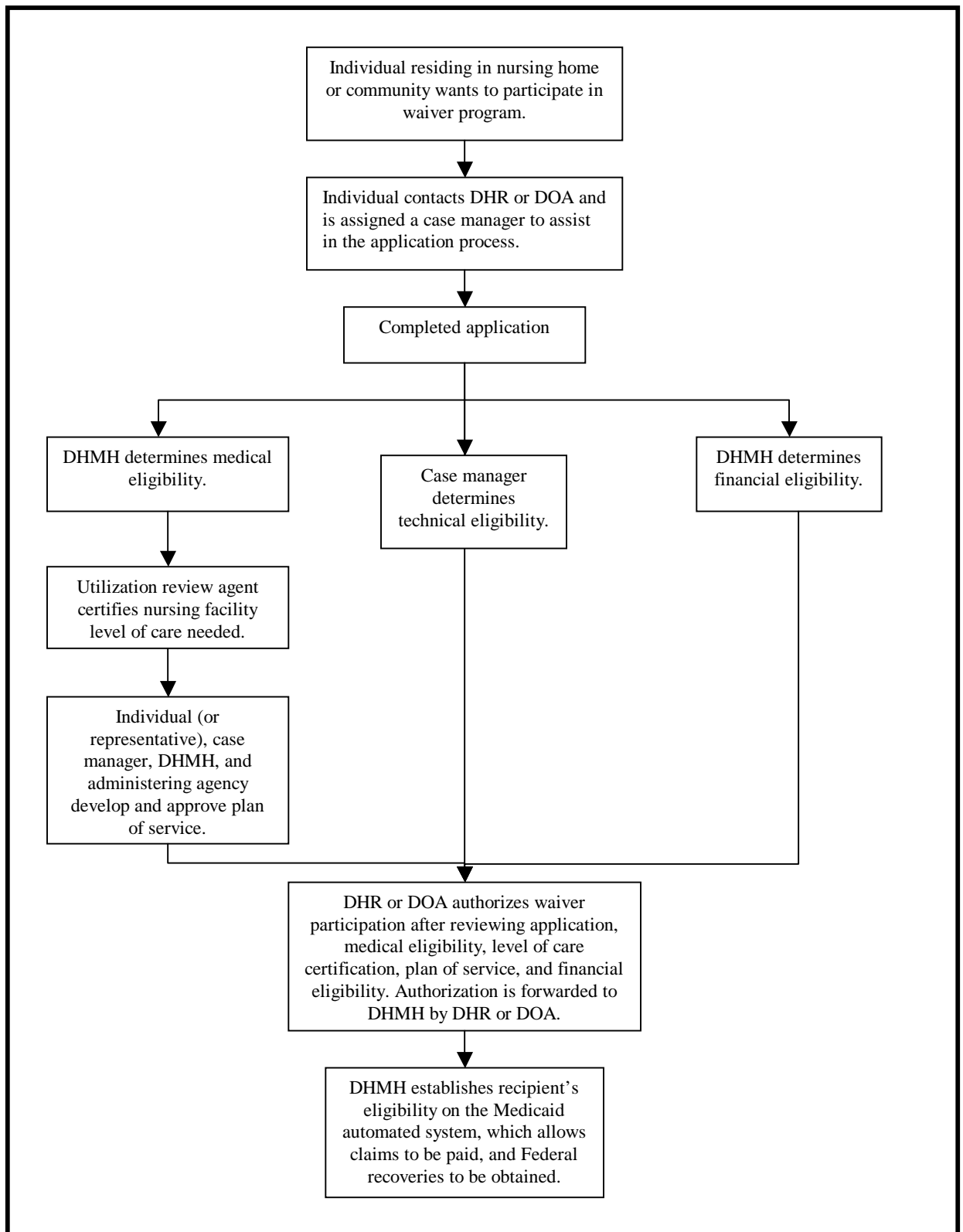
Most eligibility requirements are similar for the two waiver programs. The monthly income of a recipient for either program may not exceed 300 percent of SSI benefits (for example, monthly income could not exceed \$1,656 in 2003), and a recipient may have assets valued at no more than \$2,000 to \$2,500, depending on their eligibility category. In addition, eligible applicants for both programs require a nursing facility level of care. Under Medicaid regulations, nursing facility level of care refers to the services "provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities under the supervision of licensed health care professionals." The required level of care for all applicants is certified by an independent utilization review agent under contract with DHMH.

Application Process

The application processes for both waiver programs are virtually the same, and involve the coordination of several units within DHMH, as well as the administering agency (DHR or DOA). The administering agency assigns a case manager to each interested party, who acts as the primary contact for recipients and is responsible for assisting with the submission of an enrollment packet to the administering agency for each applicant. Case management for DHR is provided by a vendor, under contract with DHR, or for DOA, by local Area Agencies on Aging (AAAs), which are primarily local government agencies.

The enrollment packet includes a signed application, a medical evaluation, a certification of the applicant's required level of care, financial eligibility forms, and a plan of service. The plan of service demonstrates that the care required for the applicant to safely live in the community should be "cost neutral" by detailing the estimated frequency, duration, and cost of each identified service to be provided annually. The applicant, the case manager, the DHMH staff who performed the medical evaluation, and the administering agency (DHR or DOA) must all approve the plan of service. The illustration on the next page summarizes the eligibility process:

Application Process Overview



Covered Services

States may use a home and community-based services waiver program to provide a combination of both traditional medical services (for example, personal or attendant care) and non-medical services (for example, respite care, case management, environmental modifications). There is no limit on the number of services that can be offered as long as the waiver program remains “cost neutral” (as further explained on page 9 of this report), and the recipient services are necessary to avoid institutionalization. See the following chart for a list of services available to enrolled individuals under each program:

Listing of Eligible Waiver Services		
Service Type	Waiver for Adults with Physical Disabilities	Waiver for Older Adults
Assisted living services		✓
Assistive technology	✓	✓
Attendant and personal care	✓	✓
Behavior consultation services		✓
Case management ¹	✓	✓
Dietitian/Nutritionist services		✓
Environmental modifications (handicap accessibility)	✓	✓
Extended home health agency services		✓
Family or consumer training for independent living	✓	✓
Financial management of self-directed care	✓	
Home delivered meals		✓
Personal emergency response system and services	✓	✓
Respite care		✓
Senior Center Plus		✓

– Service not available

¹ Case management is provided as an administrative expense under both waiver programs. Case management is provided by vendors under contract with DHR for the Waiver for Adults with Physical Disabilities, and by the local Area Agencies on Aging (AAAs) for the Waiver for Older Adults.

In addition to services available under the waiver programs, recipients are automatically eligible for Medicaid services directly from DHMH:

- Medicaid acute, primary, and preventive services
- Medical day care
- Durable medical equipment
- Home health care (not covered by the waiver programs)
- Disposable medical supplies
- Transportation (through the local health departments)
- Pharmacy services
- Mental health services

Case Management

For both waiver programs, case managers are charged with providing three services: (1) enrollment coordination, including an initial eligibility assessment, (2) ongoing case management, and (3) periodic reassessments of recipient eligibility. DHR has contracted with three vendors to provide case management services for waiver recipients. DOA uses local AAAs, which are primarily local government agencies, to perform case management services.

Generally, the case manager must deliver the completed enrollment packet before billing for the initial eligibility assessment. The initial eligibility assessment fee is paid to the case manager regardless of whether the applicant is subsequently enrolled in the program. According to the federally-approved waiver or the grant agreement, once an applicant is enrolled, monthly ongoing case management fees can be billed if at least one ongoing case management service, such as the following, is provided during the month:

- Assisting the consumer with accessing services under the waiver plan of service
- Monitoring service delivery
- Monitoring waiver and other Medicaid service utilization and expenditures
- Mediating between the recipient and attendant care provider
- Problem solving and crisis prevention

Claims Payment

In general, DHR and DOA are responsible for processing and submitting claims for services provided to home and community-based services waiver recipients to DHMH. DHMH's Medicaid Management Information System (MMIS II) is used to process these claims for payment and to recover the related Federal funds. Included in this system are certain edits which prevent duplicate claims and claims from invalid providers or ineligible recipients from being paid.

Waiver Program Costs

In fiscal year 2003, approximately \$12.6 million and \$40.5 million in funds were spent for the Adults with Physical Disabilities and Older Adults Waiver Programs, respectively. See Figure 1 below.

Fiscal Year 2003 Home and Community-Based Services Waiver Statistics

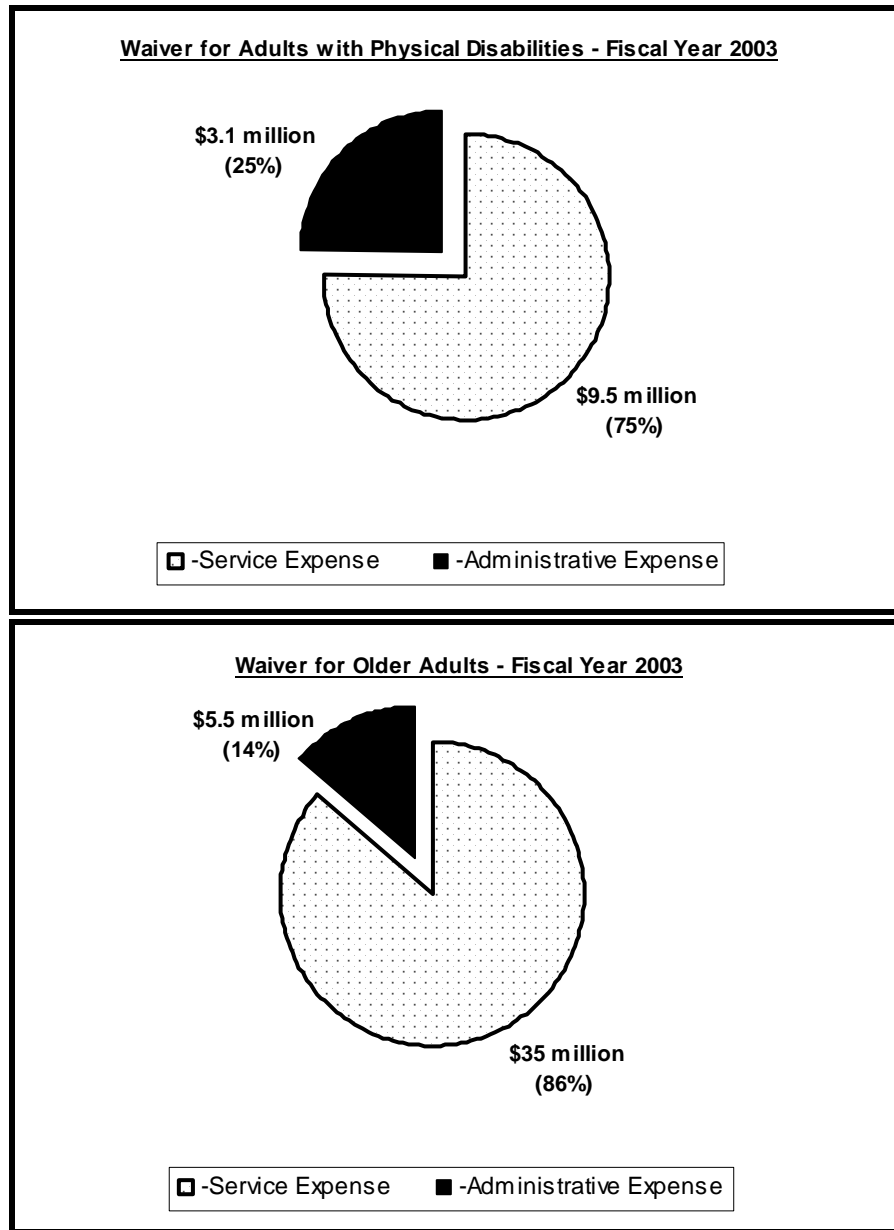


Figure 1. Approximately \$12.6 million was spent for the Waiver for Adults with Physical Disabilities Program in fiscal year 2003, and services were provided to 375 recipients. Approximately \$40.5 million was spent for the Waiver for Older Adults Program in fiscal year 2003, and services were provided to 3,135 recipients. [Based on State and Departmental accounting records; excludes DHMH administrative costs.]

Audit Scope, Objectives, and Methodology

Scope

We conducted a performance audit to evaluate the recipient eligibility and claims payment processes for the Waiver for Older Adults and the Waiver for Adults with Physical Disabilities Programs. Our audit was limited to the period from April 2001 through June 2003. Our audit was conducted under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland, and was performed in accordance with generally accepted government auditing standards. This audit was originally conducted to address allegations of improprieties related to the Waiver for Adults with Physical Disabilities Program that were received on the Office of Legislative Audit's fraud hotline.

Objectives

We had two specific audit objectives:

- (1) To determine whether the claims payment processes (for both programs) ensured that services paid for were actually provided to eligible waiver recipients, and whether services paid for had been properly authorized and were "cost neutral."
- (2) To determine whether initial recipient eligibility status (for both programs) was determined properly and in a timely manner, in accordance with State regulations, and for the Waiver for Older Adults Program, to determine whether continued recipient eligibility status was determined properly and in a timely manner.

Our audit objectives did not include a determination of the appropriateness of the services provided to the waivers' recipients, which involves a medical evaluation performed by DHMH.

Methodology

To accomplish our objectives, we reviewed applicable Federal and State laws and regulations as well as policies and procedures established by the administering agencies (DHR and DOA) and DHMH. We interviewed personnel responsible for approving eligibility determinations and authorizing claim payments. We also obtained electronic files of claims processed for waiver services rendered during fiscal years 2002 and 2003 and, after satisfying ourselves to the data's reliability, performed automated analyses of this data. In addition, certain data provided in this report for background or informational purposes were deemed reasonable, but were not independently verified.

We reviewed the case files of selected waiver recipients to determine if services paid for were documented, and were in compliance with the applicable program's criteria. We also used this information to assess the timeliness of eligibility determinations. Our audit also included a review of grant agreements and contracts for case management services provided to waiver recipients.

Fieldwork and Agency Responses

We conducted our fieldwork from May 2003 to October 2003. The Departments' responses to our findings and recommendations are included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated code of Maryland, we will advise the Departments regarding the results of our review of their responses.

Findings and Recommendations

Propriety and Validity of Waiver Service Claims

Conclusion

Our audit disclosed deficiencies in the claims payment processes for both waiver programs. Specifically, we noted that DHR routinely paid for ongoing case management services for applicants who were not enrolled in the Adults with Physical Disabilities Waiver Program, and therefore were not receiving any related waiver services. At the same time, DHR needed to enter into a contract modification to pay for the increased case management costs, since the original contract amount had been determined based on the number of persons authorized to participate in the program. In addition, we noted that a future coordination of case management services could reduce State costs. We also noted that certain provider timesheets for both programs were not required to be submitted, and therefore, neither agency had assurance that related billed services had been provided. Finally, we identified deficiencies in both programs that prevented program “cost neutrality” from being effectively monitored and could allow unauthorized claims to be paid.

Finding 1

DHR paid case managers approximately \$264,700 in fees for individuals who were not receiving waiver services, unnecessarily increasing program costs.

Analysis

DHR paid \$264,700 in Medicaid fees to case managers for individuals who were not receiving waiver services. In addition, DHR could not provide documentation to support initial eligibility assessment fees for a number of individuals. These conditions contributed to the need to modify the case management contract to increase the value and number of services to be provided. Our testing disclosed the following conditions:

- As of June 30, 2003, DHR had paid the three case management vendors approximately \$176,500 in ongoing Medicaid case management fees for 264 of the 375 currently active program recipients, during a period in which the individuals were not yet enrolled in the program. Fees were paid, on average, for three consecutive months prior to enrollment.
- DHR paid \$88,200 in ongoing Medicaid case management fees between September 2002 and February 2003 for 128 individuals who were not enrolled in the program at the time the payments were made, and were still

not enrolled as of June 30, 2003. Our test focused on six monthly invoices paid to the largest of the three case managers for the waiver program. Since annual open program enrollment is limited to the month of April, these individuals could generally not be enrolled until April 2004.

- At the time of our testing, documentation (completed enrollment application) was not available to support \$34,000 paid for initial eligibility assessment fees for 53 individuals. DHR subsequently provided us with adequate documentation for 11 of these payments, and for other unsupported payments, agreed to recover approximately \$22,000 from the case managers.

There are two types of case management fees: (1) a higher fee for case management of Medicaid services (such as attendant care), which are funded equally with Federal Medicaid funds, and State general funds, and (2) a lower fee for case management of non-Medicaid services (such as crisis intervention), which are funded only with State general funds. The case management fees noted in this finding were for case management of Medicaid services; however, because the applicants were not enrolled in the waiver program, they could not be receiving waiver services. Nevertheless, DHR believed the waiver plan allowed the State to recover, as administrative costs, Federal funds for Medicaid case management services provided to individuals who were not enrolled in the program. However, Maryland's federally approved waiver plan states that ongoing Medicaid case management fees can only be billed if at least one health-related Medicaid service is provided in a month to a waiver participant, and does not specify that Medicaid case management fees are allowed to be paid for non-Medicaid services. Federal officials whom we contacted agreed that ongoing case management fees should not be paid for individuals who are not enrolled.

In addition to the \$264,700 paid in Medicaid case management fees, DHR paid \$72,800 in non-Medicaid case management fees for these individuals using State general funds. Federal policy does not govern non-Medicaid case management fees, and DHR has not established state regulations to govern them. Nevertheless, in an effort to maximize the service delivery to the intended parties, we believe that the State should similarly pay non-Medicaid case management fees only for enrolled recipients.

Furthermore, DHR's practice of paying for services that were not authorized by the program contributed to the expected program costs being significantly exceeded. Specifically, based on the State's authorized number of individuals to be enrolled in the program for each year, DHR contracted with vendors to provide \$3.8 million in case management services (including fiscal intermediary fees) since

the initiation of the program in April 2001 through March 2004. However, because DHR had paid vendors \$4.3 million in fees as of June 2003, DHR needed to enter into a \$1.8 million contract modification to cover additional costs through March 2004.

The federally approved waiver application authorized a maximum number of recipients each year (400, 440, and 480 in the first three years, respectively); however, the availability of State matching funds limited enrollment to 150, 300, and 400 recipients in those years.

Figure 2 below illustrates actual and budgeted cumulative contract expenditures during fiscal years 2002 and 2003. (Fiscal year 2001 budgeted and actual expenditures only totaled \$100,000 and \$200,000, respectively.) It is important to note that actual waiver enrollment has been less than the maximum enrollment, on which the original contract costs were based.

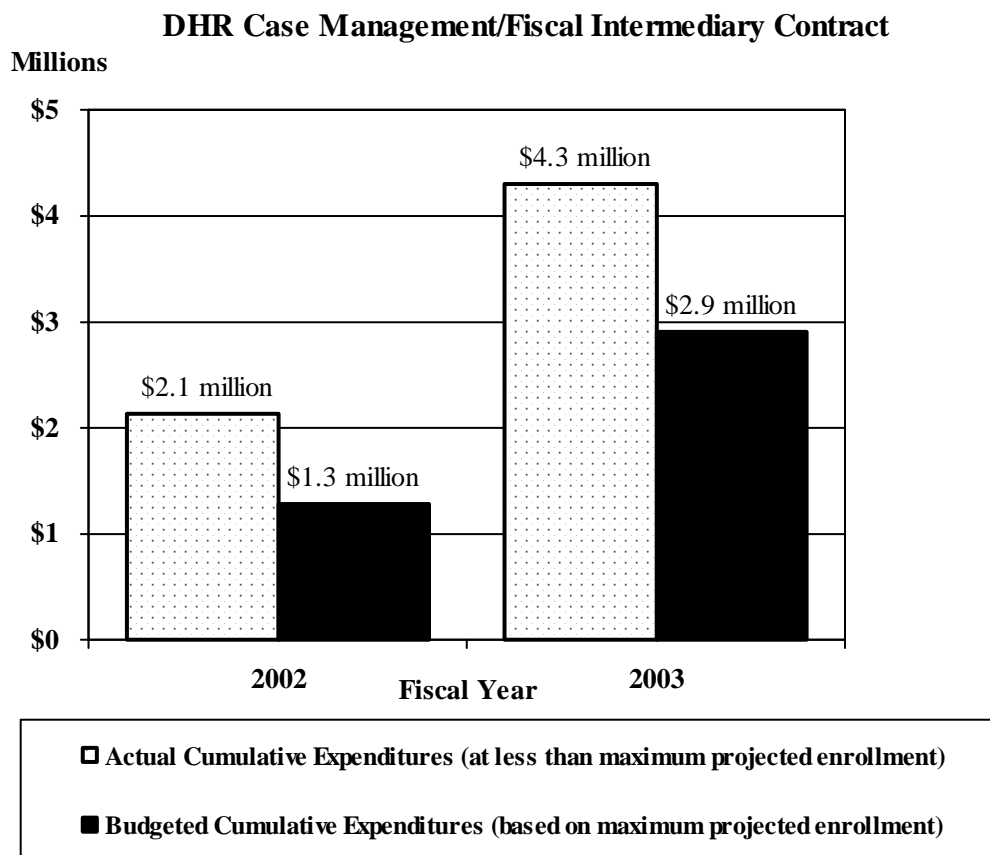


Figure 2. *Actual cumulative contract expenditures have significantly exceeded budgeted contract expenditures during fiscal years 2002 and 2003.*

Recommendation 1

We recommend that DHR restrict the expenditure of waiver funds related to Medicaid case management fees to the recipients actually enrolled in the program. In addition, we recommend that DHR ensure that adequate documentation is maintained to support all payments. We also recommend that DHR review previous payments for initial eligibility assessment fees to identify unsupported payments, and recover these payments from the case managers. Finally, we recommend that DHR establish state regulations to govern the payment of case management fees for non-Medicaid waiver services.

Finding 2

Case management services could be consolidated to improve cost efficiency.

Analysis

Our review disclosed a potential for greater cost efficiencies by consolidating case management services provided by the Medicaid-funded waiver programs with case monitoring services provided by other State Medicaid programs. Fiscal year 2003 payments totaling approximately \$283,000 were made by DHMH for Medicaid case monitoring services for the same recipients receiving case monitoring services under one of the waiver programs. Specifically, we noted 399 enrolled waiver recipients (331 recipients in the Older Adult Waiver and 68 recipients in Adults with Physical Disabilities Waiver) for which case monitoring service fees were reimbursed to the local health departments as part of the State Medicaid plan, and case management service fees were also paid to private vendors or local Area Agencies on Aging (AAA) under the respective waiver program.

The case monitoring services provided under the Medicaid State plan and the case management services provided under the waiver programs are similar. These services include development of individual plans of care, supervision of individuals providing services to the recipients, and monitoring the quality of care provided to the recipients through quarterly visits. Consequently, these 399 waiver recipients were monitored by two different providers serving a similar purpose, which ultimately is to ensure that the care provided allows these individuals to live safely in the community. We believe the monitoring of the delivery of services provided to these recipients could be a coordinated effort, with a resultant reduction in State costs.

Recommendation 2

We recommend that DHMH evaluate the responsibilities of the providers performing case monitoring services under the State Medicaid plan and the waiver programs and determine if a consolidation is practical to reduce State costs.

Finding 3

Adequate supporting documentation was not required, and periodic audits were not conducted to verify the accuracy of certain provider claims paid for both waiver programs.

Analysis

The accuracy of certain billings was not verified to ensure that services billed by various providers were actually performed. Such services include attendant care (DHR) and personal care (DOA) provided to waiver recipients as well as structural modifications to recipients' homes for handicapped accessibility. Specifically, we noted the following conditions:

- DHR did not require agencies that provided attendant care services to submit timesheets or recipient certifications to support the amounts billed. We did note that timesheets were submitted by self-employed attendant care providers which were signed by the recipient, or his or her representative, certifying that the services were received. However, there were no similar certifications provided by the attendant care agencies. DHR paid approximately \$4 million to attendant care agencies, and approximately \$2.1 million to self-employed attendant care providers in fiscal year 2003.
- DOA did not require personal care providers, both agencies and self-employed providers, to submit timesheets or recipient certifications to support the amounts billed. DOA paid approximately \$14 million to personal care providers in fiscal year 2003.
- Neither DHR nor DOA had established procedures to consistently conduct periodic provider audits to verify that services paid for were actually provided. These audits would verify payments to provider source documents (such as payroll records and contractual invoices for structural modifications).

We were informed by DHR management that, based on recipient complaints that services were not provided in accordance with the applicable plans of service, an audit was conducted in April 2003 of one of the larger attendant care agencies. This audit identified claims totaling \$55,347—representing 41 percent of provider invoices tested—for which no documentation was available to substantiate that services were actually provided. After we questioned DHR about the status of this audit, they agreed that any overpayments identified would be pursued. DHR also forwarded their findings to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General. No similar audits had been conducted of any of the other 47 attendant care agencies at the time of our review.

Recommendation 3

We recommend that DHR and DOA establish procedures to ensure that provider payments are appropriate and for legitimate purposes. For example, providers should be required to submit adequate documentation (such as recipient certification, timesheets) to support their claims for services provided to waiver recipients. We further recommend that periodic provider audits be conducted to ensure that services billed were actually provided. Finally, we recommend that appropriate corrective action be initiated as a result of current and future audits (recover overpayments, contact MFCU).

Finding 4

DHR and DOA were not effectively monitoring the hours of care provided or the “cost neutrality” of participant care.

Analysis

DHR and DOA did not effectively monitor waiver recipient service utilization or the ultimate “cost neutrality” of the home and community-based services waiver programs. Specifically, we noted that DHR and DOA did not periodically reconcile the service costs (such as personal care and attendant care services) per the payment records (MMIS II) with each recipient’s plan of service to ensure that recipients received the proper number of hours of care and that services received were authorized by the plan of service. Consequently, waiver service providers could be reimbursed for unauthorized services or may not be providing all necessary services. Furthermore, since the individual recipient plans of service are designed to meet the “cost neutral” requirements (as further explained on page 9 of this report), the eligibility of individual recipients could be jeopardized, as well as the “cost neutrality” of the overall programs.

Our testing at DOA disclosed that appropriate services were not always being provided in accordance with the existing plans of service. Specifically, our test of personal care services provided to 30 recipients of the Waiver for Older Adults in January 2003, disclosed that for seven recipients, claims were not paid in accordance with the approved plans of service. Specifically, for four recipients, claims were paid for 330 hours of service (costing in excess of \$4,000) that exceeded the recipients' authorized daily hours of service. Routine occurrences of this condition could result in a recipient's total annual authorized units of service being exhausted in less than a year, and if services continued, an individual's "cost neutrality" and continued participation in the waiver program could be affected. The remaining three recipients received either more or less than their required units of service for a particular day. Providing fewer than the authorized units of service could impact a recipient's quality of care.

Our limited testing at DHR did not disclose any specific examples where services were not provided in accordance with the plan of service.

Recommendation 4

We recommend that DOA and DHR establish procedures to monitor waiver recipient service utilization on a periodic basis (for example, quarterly) to ensure that appropriate services are provided and that recipients remain "cost neutral." Specifically, we recommend that DOA and DHR reconcile waiver expenditure data from MMIS II with the respective plan of service. This monitoring should include verification to each plan of service to ensure that recipients received the proper number of hours of service and that services received were authorized.

Propriety and Timeliness of Waiver Eligibility Determinations

Conclusion

Our audit disclosed that recipient eligibility status for both programs was not determined in a timely manner and properly documented, in accordance with State regulations. We also noted that DHR did not ensure that comprehensive plans of service were submitted timely or were properly completed, in accordance with State regulations and federal policy. Finally, DOA did not complete annual eligibility redeterminations in a timely manner.

Finding 5

Eligibility determinations for applicants to both waiver programs were not processed timely, and comprehensive plans of service were not received timely or properly completed.

Analysis

Eligibility determinations for applicants to both waiver programs were not processed timely; see Figure 3 below:

Timeliness of Applicant Processing		
	DHR	DOA
Required timeframe for application processing per State regulation	60 days	30 days
Number of applications tested	25	45
Period covered by applications tested	April 2001 to August 2002	February 2001 to February 2003
Number of applications completed after the required timeframe	20	45
Processing time for untimely applications	64 to 320 days	42 to 359 days
Number processed later than 90 days	13	35

Figure 3. *The majority of the waiver applications tested were not processed timely in accordance with State regulations.*

In addition, based on tests only performed at DHR, we also noted that DHR did not ensure that case management vendors submitted a comprehensive plan of service, which identifies specific providers for each required service, within 60 days of enrollment in the waiver program as required by Federal policy. Specifically, our test of 10 recipients enrolled between October 2001 and October 2002 disclosed that 8 plans of service were submitted to DHR late—on average, 128 days after they were due. Furthermore, for 24 of the 25 plans of service tested, DHR did not document its approval of the plans for appropriateness as required by State regulations.

Recommendation 5

We recommend that DHR and DOA comply with State regulations and ensure that eligibility determinations are processed timely. We further recommend that, in accordance with State regulations and Federal policy,

DHR ensure that comprehensive plans of service are submitted timely and that approvals of plans of service are properly documented.

Finding 6

Annual required eligibility redeterminations for the Older Adults Waiver recipients were not properly completed or processed timely.

Analysis

Annual required eligibility redeterminations for Older Adults Waiver recipients were not properly completed, or were not completed timely. Our test of 38 waiver recipients, who were active as of June 2003, disclosed that DOA could not document that complete eligibility redeterminations had been properly completed for 28 of the recipients. These recipients had been enrolled between 13 and 28 months. In addition, for 6 of the remaining 10 recipients, redeterminations were completed between two and five months after the required dates.

The eligibility redetermination process has three components: financial eligibility, as determined by DHMH; technical eligibility, verified by the AAA; and medical eligibility, as certified by an independent utilization review agent. To ensure that waiver recipients remain eligible for the program, State regulations require this entire process to be completed annually, with the first redetermination to be completed within 12 months of the initial enrollment date.

Recommendation 6

We recommend that DOA ensure that all components of the annual eligibility redetermination process are adequately documented and properly completed within appropriate time frames.

Other Significant Issues Noted

Conclusion

Our audit work at DHMH and DOA disclosed three additional issues that were not included in our original audit objectives. Specifically, DOA did not ensure that required criminal background checks were documented for all Older Adults Waiver providers, nor did they implement adequate provider complaint resolution procedures. Additionally, DHMH did not adequately monitor the quality of care provided to recipients of the Waiver for Adults with Physical Disabilities.

Finding 7

Required criminal background checks were not always documented for personal care aides currently providing services to recipients of the Older Adults Waiver.

Analysis

Required criminal background checks were not always documented for personal care aides currently providing recipient services in the Older Adults Waiver Program. Specifically, we tested 51 personal care aides (11 self-employed aides and 40 employed by personal care agencies) to determine whether DOA had documentation of a criminal background check on file for these providers. There was no documentation of background checks maintained by DOA for 26 of the 40 individuals employed by the personal care agencies.

To ensure safety for waiver recipients, State regulations require that an individual submit to a criminal background check in order to qualify as a personal care aide (including those employed by an agency) before providing services under the waiver program.

Recommendation 7

We recommend that DOA ensure that criminal background checks are obtained for all personal care providers participating in the Older Adults Waiver program.

Finding 8

DOA did not have adequate provider complaint resolution procedures.

Analysis

DOA did not have a formal complaint log and had not established a standardized process to investigate and resolve provider complaints, such as those regarding recipient safety and provider billing discrepancies.

For example, DOA became aware of potential billing irregularities by a provider as a result of a review conducted by a local AAA in November 2002, but took no action to investigate the situation. In this case, the AAA identified an assisted living facility that was informing recipients and their family members of the difference between the higher reimbursements that would be received from private insurance companies, and the standard waiver program rate that was paid. It was believed by the AAA that the provider was attempting to recover the payment difference from the recipients or their families, which is not allowed by Medicaid

regulations. While this provider was included as part of a routine review conducted by DHMH on unrelated issues (quality of care), the billing discrepancy was not investigated and resolved, and the provider continues to provide services in the waiver program.

DOA also received a complaint from another AAA in August 2003 about a personal care provider not providing services to a recipient. Because DOA had no complaint resolution procedures, DOA informed the AAA to forward the complaint to the Office of Legislative Audits' Fraud Hotline. This complaint was investigated during our audit and we determined that, for one recipient, this provider was paid in excess of \$2,000 for services that were not preauthorized; for another recipient, 136 hours of planned services were not provided as required. Based upon our investigation, the DOA referred this complaint to the Office of the Attorney General's Medicaid Fraud Control Unit in February 2004.

Recommendation 8

We recommend that DOA establish formal procedures to investigate provider complaints, including a complaint log, which require the resolution of each complaint be properly documented. For complaints that result in irregularities, we further recommend that DOA refer legitimate complaints to the appropriate agencies (such as the Office of the Attorney General's Medicaid Fraud Control Unit) for further investigation. We further recommend that the provider previously identified by the AAA with billing irregularities be investigated and corrective action initiated, including referrals to the appropriate agencies, if the complaint is determined to be legitimate.

Finding 9

The quality of care provided to recipients of the Waiver for Adults with Physical Disabilities was not monitored by DHMH.

Analysis

DHMH did not monitor the quality of care provided to recipients of the Waiver for Adults with Physical Disabilities Program. According to the Quality Assurance Plan associated with this waiver program, DHMH should conduct an annual retrospective review of a random five percent sample of waiver participants to monitor quality assurance activities including reviewing records from the case manager and conducting participant interviews. As of December 2003, however, DHMH had not conducted the required reviews of DHR waiver participants since the program began. Accordingly, there is no assurance that the quality of care being provided to recipients of this waiver program is adequate.

In response to a United States General Accounting Office report issued in June 2003, the Federal Centers for Medicare and Medicaid Services (CMS) maintained that the states, not the Federal government, were primarily responsible for overseeing quality of care. Finally, a December 2003 report issued by the Federal CMS, which focused on the implementation of DHR's quality assurance process, raised concerns about a general lack of quality of care monitoring.

Recommendation 9

We recommend that DHMH perform annual reviews to monitor quality assurance activities for the Waiver for Adults with Physical Disabilities, as specified in the memorandum of understanding.



STATE OF MARYLAND

APPENDIX

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

May 24, 2004

Mr. Bruce A. Myers, CPA
Legislative Auditor
Department of Legislative Services
Office of Legislative Audits
Maryland General Assembly
301 West Preston Street, Room 1202
Baltimore, Maryland 21201

Dear Mr. Myers:

Attached is the Department of Health and Mental Hygiene's response to the Department of Legislative Services' performance audit report for the Home and Community-Based Services Waivers that was conducted in 2003.

If you have any questions or require additional information, please do not hesitate to contact Jill Spector on my staff at 410-767-5248.

Sincerely,

Nelson J. Sabatini
Secretary

Attachment

cc: Secretary Christopher J. McCabe, DHR
Secretary Jean W. Roesser, MDoA
Mr. Ellwood L. Hall Jr., DHMH
Mr. Mark Leeds, DHMH
Ms. Jill Spector, DHMH
Ms. Susan J. Tucker, DHMH
Mr. William Watts, DHMH
Ms. Jane Wessely, DHMH

Issues:

During the course of our audit, other issues came to our attention at DHMH and DOA, beyond the objectives of the audit, that warrant mentioning in this report. For the Older Adults Waiver Program, we noted that criminal background checks were not consistently obtained for all participating providers, and that appropriate complaint resolution procedures were not in place. We identified recipient complaints that had not been sufficiently investigated or appropriately resolved. With respect to the Adults with Physical Disabilities Waiver Program, we noted that DHMH had not conducted reviews to monitor the quality of care provided to the recipients, as required by the DHR Quality Assurance Plan.

Auditor's Recommendation:

Although DHR and DOA operate the respective waivers, DHMH retains ultimate responsibility for the Medicaid program in Maryland. It is essential that DHMH take the lead in ensuring appropriate corrective action is taken by both agencies. Specifically, we recommend that the administrative responsibilities for each waiver program be evaluated, and that appropriate payment procedures be established to ensure the efficient and effective use of State resources. Also, we recommend that an effective process be developed for ensuring that provider claims are only paid for appropriate and authorized services, in accordance with regulatory requirements. In addition, all opportunities for cost recovery or savings be vigorously pursued so that services can be provided to the maximum number of recipients authorized under the waiver programs. We further recommend that eligibility determinations be completed and documented in a timely manner, in accordance with State regulations. Finally, DOA must ensure that criminal background checks are obtained for personal care providers and formal complaint procedures must be established, and DHMH must monitor the quality of care for recipients of the Waiver for Adults with Physical Disabilities Program.

DHMH Response:

The Department agrees with the Auditor's recommendation that increased oversight of the administration of the waiver programs is needed. We will continue to monitor the waiver programs as is required of the single State Medicaid agency to ensure that corrective action is taken in a timely manner. We agree to accept responsibility to ensure that there are appropriate quality assurance reviews, payment procedures, timely eligibility determinations and ongoing evaluation of the efficiency and effectiveness of the program.

Finding 2:

Case management services could be consolidated to improve cost efficiency.

Auditor's Recommendation:

We recommend that DHMH evaluate the responsibilities of the providers performing case monitoring services under the State Medicaid plan and the waiver programs and determine if a consolidation is practical to reduce State costs.

DHMH Response:

The Department will evaluate the responsibilities of the providers performing case monitoring services under the State Medicaid plan and the waiver programs. However, the Department does not believe that a consolidation of waiver case management and nurse monitoring under the State Plan program is a practical strategy for reducing costs.

The services are very different in scope. Case managers are responsible for developing and overseeing the comprehensive waiver plan of care (which includes all of the waiver and State Plan services a participant needs to be safely maintained in the community through the waiver) and assuring cost effectiveness of the plan of care. Personal care nurse monitors are responsible for developing an individualized plan for personal care services for each participant, training the aide, and then monitoring and evaluating the work of the aide and the continuing appropriateness of the personal care services.

It should also be noted that a relatively small subset of waiver participants also receive personal care services under the State Plan. When this occurs, it is usually intended to gain cost efficiency by accessing an entitlement service which is paid at a lower rate than the waiver attendant care services.

Finding 9:

The quality of care provided to recipients of the Waiver for Adults with Physical Disabilities was not monitored by DHMH.

Auditor's Recommendation:

We recommend that DHMH perform annual reviews to monitor quality assurance activities for the Waiver for Adults with Physical Disabilities, as specified in the memorandum of understanding.

DHMH Response:

The Department agrees with this finding and the recommendation to perform annual reviews for the Waiver for Adults with Physical Disabilities. Planning and training activities to support this activity began in FY 2003. In November 2003, the Department implemented annual reviews for this waiver. As of January 2004, the Medicaid Division of Waiver Program's Inspection of Care Team completed the first annual review.

May 25, 2004

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Christopher J. McCabe
Secretary

Mr. Bruce Myers
Maryland General Assembly
Department of Legislative Services
Office of Legislative Audits
301 West Preston Street, Room 1202
Baltimore, Maryland 21201

Dear Mr. Myers:

Enclosed is the Department of Human Resources' response to the performance audit report on the Medicaid Waiver Programs: Home and Community-Based Services for Adults with Physical Disabilities and Older Adults.

We appreciate your recommendations and support of our programs to provide quality services to this vulnerable population of adults with disabilities. Please do not hesitate to contact me at 410-767-7109 if you need additional information or wish to discuss further.

Sincerely,



Christopher J. McCabe
Secretary

Enclosure

cc: Secretary Nelson J. Sabatini, DHMH
Angelia Butler, Assistant Inspector General, DHR
Cathy Shultz, Office of Attorney General, DHR
Elizabeth Seale, Deputy Secretary of Planning, DHR

Department of Human Resources Community Services Administration

Response to Department of Legislative Services Medicaid Waiver Programs Home and Community-Based Services for Adults with Physical Disabilities and Older Adults April 2004

The Department of Human Resources (DHR) has received the performance audit report noted in the April 28, 2004 letter to Secretary McCabe pertaining to the Medicaid Waiver Programs Home and Community-Based Services for Adults with Physical Disabilities and Older Adults.

We agree that “opportunities exist to improve the cost efficiency of service delivery and to enhance accountability and fiscal controls” for all programs and services provided by the State of Maryland. Over the course of the past year, we have developed and initiated several processes, controls, and policies to streamline eligibility, enhance quality and fiscal accountability of services, and maximize resources.

Although we agree with three of the findings, there are areas that are in conflict with the Department’s findings and interpretation of the Federal and State requirements. There are several regulations, requirements, and assurances that must be met for states to receive approval and implement a waiver program. The waiver programs have several similarities and specific differences in terms of processes and services available. We noted some differences in the background description of the Home and Community-Based Services for Adults with Physical Disabilities known as Living at Home: Maryland Community Choices Waiver. We are submitting this response to individually address each finding, to clarify and substantiate our interpretation of Federal policy, and provide additional information concerning processes and systems to resolve disputed issues.

Background

The Living at Home: Maryland Community Choices (LAH:MCC) Medicaid Waiver program is the first consumer-directed home and community-based services waiver for adults with physical disabilities age 21 – 65. It supports the President’s New Freedom Initiative and the Supreme Court’s Olmstead Decision. This program began April 1, 2001, recruiting both providers and participants while maneuvering a complex eligibility system that involves the ongoing interactions among several local and State agencies. Over the past two years, the program has processed hundreds of provider and participant applications, evaluated processes and policies to streamline eligibility, formed a consumer advisory committee, and conducted several outreach, training, and speaking engagements, including regional provider fairs. The waiver recently received federal approval for renewal for an additional five years.

The Department of Health and Mental Hygiene (DHMH), as the State Medicaid agency, is the only State Department permitted to apply for and amend a waiver application. Eligibility, enrollment, and payments are all processed through various DHMH divisions and units. DHR is the day to day administering agency. DHR oversees case management and fiscal intermediary contracts and authorizes or certifies providers and participants for DHMH to enroll and pay.

As with any new program, challenges and barriers present themselves during the initial start up years. Projected processes and policies continue to be examined and changed to streamline eligibility, meet Federal policy mandates, and address challenges of implementation. OPAS shared several challenges with the auditor including the complex eligibility process, multiple entities involved, flood of applicants, and the inadequacy of DHR and DHMH staffing levels. Despite these challenges, we are committed and remain focused on the safety, crisis, and independence needs of Marylanders with disabilities who seek waiver services. With the growing number of individuals with disabilities, the aging population, and current economic times, we clearly understand and seek methods to improve our cost efficiency and fiscal controls while remaining focused on the delivery of quality services.

Finding 1

DHR paid case managers approximately \$264,700 in fees for individuals who were not receiving waiver services, unnecessarily increasing program costs.

Response:

We disagree with the auditor's finding and misinterpretation of federal policy related to ongoing case management services allowable under the program. **Case management services are not contingent on enrollment of the individual.** OPAS approved ongoing case management services provided to individuals during the eligibility assessment process and therefore prior to entering the waiver based on the approved federal application, Centers for Medicare and Medicaid Services (CMS) policy (Olmstead Letter #3), and the case management service contracts. There is no requirement for enrollment in order to receive ongoing case management services. In addition, payment to case management agencies for individuals eventually not enrolled in the program is acceptable to CMS.

After reviewing the 53 cases noted in the auditor's worksheet related to assessment fees, OPAS files, and case management documents, we concur that 42 cases lacked appropriate documentation. Therefore, we agree with the auditor's recommendation to take appropriate action to recover approximately \$22,000 from the case management agency for payment of 42 initial assessments and to review prior payments for initial assessment fees.

Ongoing Case Management Services

The federal application for the waiver program was submitted to the federal Centers for Medicare and Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), on May 7, 1999 and approved September 8, 2000.

As noted by the auditor, in the original waiver application, Attachment A outlines “Waiver Administration and Case Management”. Ongoing case management is defined on pages 93-94 as stated below:

- “4. Ongoing case management/service coordination (billed if at least **one service** is provided in a month, including services provided at the participant’s request for a participant receiving the consumer–employed model of attendant care services)
- a. Assists the consumer with accessing services in the waiver plan of care.
 - b. Monitors service delivery – performance and compliance of waiver providers, quality of care, whether the consumers’ needs are met, consumers’ health and safety, and whether any changes are necessary.
 - c. Monitors waiver and other Medicaid service utilization and expenditures to assure compliance with consumers’ waiver plans of care and to assure the waiver’s aggregate cost-effectiveness.
 - d. Mediates and attempts to remedy the problem (including providing this service upon the request of the participant receiving the consumer-employed model of attendant care) when the participant’s behavior, action, or environment (1) does not allow the attendant to perform the needed services recommended in the waiver plan of care or (2) presents a threat to the attendant’s physical well-being.
 - e. Problem–solving and crisis intervention. Note: RFP will request bidders to state how they will coordinate with any other case manager for participants who have case managers in other programs, such as, HealthChoice and Social Services to Adults.”

“Services” encompasses the coordination and facilitation of community, local, State, and waiver services. This includes services recommended by the Adult Evaluation and Review Services (AERS) noted in the plan of care (see 4. a. above); coordination with other programs such as food stamps (see 4. e. above); Medicaid State Plan (see 4. c. above); and housing subsidies, non-Medicaid State programs such as Social Services to Adults, etc. (see 4. e. above) in addition to monitoring waiver service delivery (see 4. b. above).

Case management services are further outlined in the original request for proposal (RFP). The RFP specifies that the case managers shall assess, coordinate and link the participant with home and community based services and non-waiver services and programs from various community providers, State and local departments. Due to the various needs of this vulnerable adult population, **“services”** are broadly defined to include services other than waiver and Medicaid State Plan Services. Case management functions include (1) assessment, planning, and enrollment coordination, (2) ongoing case management (service coordination and monitoring), and (3) reassessment (redetermination of waiver eligibility and development of plans).

Ongoing case management (service coordination and monitoring) is defined in two parts, Medicaid Case Management and Non-Medicaid Case Management. Medicaid Case Management includes services to access, coordinate, and monitor Medicaid services, which

includes both Medicaid State Plan and Waiver services. Applicants who are Community Medicaid-eligible may access any necessary Medicaid State Plan Service as entitlement. All waiver participants are entitled to Medicaid State Plan Services. Non-Medicaid Case Management includes services to access, coordinate, and monitor all other services that are not provided by Medicaid (such as applying for housing programs, home-delivered meals, food stamps, etc.).

Applicants have limited resources and assets. Individuals in nursing homes have limited access to telephones (they often have to use a pay phone or lack the mobility to dial) to inquire about services and supports available in the community.

Case managers have been extremely effective in preventing deterioration of current medical conditions, hospitalizations, and institutionalization by coordinating both Medicaid and Non-Medicaid services for individuals prior to their waiver eligibility determination. Case managers have communicated with special needs coordinators in Managed Care Organizations (MCO), which can be difficult to navigate to request and access referrals for additional services available through the Medicaid MCO (e.g., physical, occupational, and speech therapy, neurology, etc.). They have also coordinated application to various State and local programs available for crisis intervention and so that the applicant can make an educated decision about which program would best meet their needs and prevent deterioration of their health and potential evictions.

Case management agencies are required to submit a monthly report and document Medicaid and/or Non-Medicaid case management services provided for that month. To prevent duplicate billing, the waiver does not allow case management agencies to bill for the case management services the same month they bill for assessment, planning, and enrollment coordination or reassessment. OPAS has received several invoices for which the case management agency billed for Medicaid case management only and did not bill for Non-Medicaid case management services.

CMS continually reviews their policies and practices to comply with the Supreme Court's Olmstead Decision and the Americans with Disabilities Act. In a Medicaid State Director's letter referred to as Olmstead Update Number 3 (dated July 25, 2000), CMS provided an "update of the Health Care Financing Administration activities to support the Supreme Court's decision in Olmstead and the Americans with Disabilities Act to enable individuals with disabilities to live in the most integrated setting appropriate to their needs." It also summarizes policy clarifications or policy reform designed to facilitate states' efforts to support the ADA.

On page four of this letter there is a description of the different kinds of case management services states may use under the Medicaid program. LAH:MCC uses administrative case management services. **The letter clearly states case management activities may be paid for and matched by CMS for individuals "even if the person is not eventually served in the community"** (see excerpt below). Payment to case management vendors for individuals eventually not enrolled in the program is acceptable and necessary for the reasons described above.

To date, the State has had no federal disallowance for case management services and does not anticipate a future disallowance based on CMS' policy. The State has further clarified the scope of case management services in both the waiver renewal application and case management request for proposals. Given the medical complexity and vulnerability of these individuals, these services are critical to support community independence and decrease Medicaid long-term care nursing home cost. Medicaid nursing facility cost is an average of \$65,000 per individual per year. The waiver program's projected average plan of service cost is \$31,417 per individual annually based on actual service claims.

Excerpt from Department of Health and Human Services – Health Care Financing
Administration's Olmstead Update No. 3 to State Medicaid Directors

*“Administrative Case Management may be furnished as an **administrative** activity, necessary for the proper and efficient administration of the State Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of State plan.”*

Initial Eligibility Assessment Fee

Assessment, planning, and enrollment coordination involves the facilitation and/or development of multiple documents for application to the waiver program such as the AERS assessment, nursing facility level of care certification, and waiver plan of service. The case management agency is required to submit specific documents known as the “waiver enrollment packet” in order to be reimbursed for this function. The waiver enrollment packet includes the waiver application, initial waiver plan of service, AERS assessment, technical and financial eligibility documents, and may include a “special waiver participation request” (if applicable) as noted in the RFP Section 3.5 Deliverables A. Waiver Enrollment Packet, page 33.

Our policy is to verify deliverables prior to payment authorization. The responsibility for approving payment for case management invoices, for the period of the auditor's review, was the work of an employee who is no longer working at OPAS.

To facilitate approval of payment authorization, OPAS developed an application and reassessment (also known as redetermination) tracking form in May 2003 which was shared with the auditor. OPAS Waiver Specialists who oversee the individual cases assigned to the case management agency maintain these documents. The Specialist records the receipt date of all initial and annual reassessments in the tracking forms. The date also is recorded in the Participant database.

OPAS fiscal staff receives and processes all case management invoices. Fiscal staff are required to verify receipt of initial and annual reassessments before authorizing payment. Fiscal staff will review the application and reassessment tracking forms, database, and review the actual case file (if necessary) to verify receipt of the item. If documentation cannot be found, the Specialist is contacted for further investigation. Assessments invoiced without proper documentation are denied. Since March 2003, with the replacement of fiscal staff, 23 assessments have been denied due to lack of proper documentation.

Contract Modifications

Federal eligibility regulations ensure that every one has a right to apply. Applicants cannot be pre-screened even if they do not meet basic technical or medical eligibility. The case management and fiscal intermediary contract amount was based on variables such as projected enrollment trends, percentage of participants who would utilize the consumer employed model, number of attendants, and average length of stay on the program. The public demand for the program was higher than expected and therefore the program underestimated the number of applicants that would apply. The program initially demonstrated a 40% denial rate and therefore it took several applicants to get one eligible participant. Therefore, the program increased the overall contract amount, with the Board of Public Works approval, through contract modifications while still remaining within its budget.

Prior to the development and implementation of the DHMH's Waiver Services Registry Policy in late November 2002 and amendment to the Federal application, DHR could not limit the number of applicants to the waiver program. As a result, the program provided case management assistance with the application process to over 700 individuals.

The program is prohibited from exceeding the number of approved waiver slots within a waiver year unless approval to increase the slots is received. The waiver has Federal approval for 400 slots the first year, 440 slots the second year, and 480 slots the third year. The number of people the program can serve is more restricted by the available funding. Therefore if a waiver participant leaves the program during the course of the waiver year and the program has not exceeded its approved slot number, the program can enroll additional individuals providing there is funding to support their services. Case management contracts do not guarantee a number of individuals to be served, as noted in the Request for Proposal. The number of approved slots does not restrict case management services.

OPAS has several procedures in place to ensure that contract expenditures are monitored and only allowable expenses are incurred. With the closure of the waiver in December 2002, individuals residing in the community who express interest in the program are placed on the Waiver Services Registry. To date there are over 900 names on the list. Per House Bill 478 "Money Follows the Individual", passed in the 2003 Legislative Session, individuals residing in a nursing facility (paid by Medicaid for at least 30 days) can apply and cannot be denied due to lack of funding. Therefore, the program is required by law to continue to process nursing facility applications and provide case management services.

Finding 2

The Department of Health and Mental Hygiene is responding to this finding.

Finding 3

Adequate supporting documentation was not required, and periodic audits were not conducted to verify the accuracy of certain provider claims paid for both waiver programs.

Response:

We agree with the auditor's finding. The waiver programs did not initially require documentation of the delivery of services, with the exception of the DHMH Billing Form 248 and the LAH:MCC requirement for timesheets for independent attendant care providers. With recommendations provided during the CMS site visit in May 2003, OPAS developed several new documents, including Provider Service Records, to verify services provided to program participants for all providers of attendant care, nurse monitoring, consumer training, and family training. OPAS will also be developing specific documentation requirements related to environmental adaptations.

As noted by the auditor, OPAS Quality Assurance staff had previously conducted an on-site audit of an attendant care agency for which the provider failed to provide timesheets to support the agency's claims. On September 23, 2003, DHMH and OPAS met with this provider to discuss billing practices, policies, and program requirements. In addition, OPAS requested copies of all supporting documentation for billed services for the months of March and May 2003. After review of all documents provided and at OPAS' request, the Department's Assistant Attorney General sent the matter to the DHMH Office of the Attorney General/Medicaid Fraud Unit on October 20, 2003. These actions were all initiated prior to receipt of the audit findings. The Medicaid Fraud Unit recently completed their investigation and has verbally advised OPAS they could not prove intent to defraud in a criminal action but that civil recovery is in order. The supervisor will review the investigator's recommendation and a final ruling is expected.

OPAS has since requested information from 11 additional agencies and completed reviews of 7 agencies. OPAS plans to continue to audit waiver service providers for accuracy of billed invoices (starting with the agencies that receive the largest reimbursements) and compliance with provider qualifications.

It is OPAS policy to refer all suspected fraud to the Medicaid Fraud Unit.

Finding 4

DHR and DOA were not effectively monitoring the hours of care provided or the “cost neutrality” of participant care.

Response:

We disagree with the auditor’s finding. The program is designed to be flexible and meet the individual needs of each participant while ensuring cost neutrality. OPAS utilizes various methods and strategies to effectively monitor services utilization and cost neutrality. Service frequency is noted as weekly or monthly in the POS. This provides consumer choice and flexibility of service delivery especially for attendant care services. Individuals with disabilities and advocates have always requested a personal assistance program that was flexible to meet the individual needs of the person with a disability. Services should be provided when and where needed. Participants can project the need for services each day. However, life is not static and changes occur. For instance, a waiver participant may have a POS that authorizes 56 hours of attendant care a week. This could equate to 8 hours a day. A family member provides the remaining unpaid care after they get off work. If the family member is delayed due to work, a snow storm, hurricane, etc. then the person is without support and care. An attendant could work an additional hour to support the individual until the unpaid family member gets home. The waiver participant would then need to adjust the hours of service for the remainder of the week to not exceed the 56 hours authorized. Another example would be if this same individual had a sister visiting from out of town for a few days. The sister could provide the care needed without pay for those days. The participant is not required to use only paid attendant care.

OPAS utilizes the following processes and methods to monitor services utilization and cost neutrality:

- a. Analysis of Paid Claims
 - b. Provider Service Reports
 - c. DHMH Federal Reporting (HCFA 372)
 - d. Fiscal Audits
 - e. New requirements in case management and fiscal intermediary contracts
-
- a. Analysis of Paid Claims

OPAS has historically utilized claims data to project service utilization which is a comparison of authorized services to paid claims services. This information is shared with the case management agencies. Case managers are required to monitor services delivery and cost neutrality.

- b. Provider Service Records

OPAS implemented a formalized "Provider Service Record" which requires providers of attendant care, nursing supervision of attendants, consumer trainers, and family trainers to

document service delivery, identify health or safety issues, hours of services, and sign-off by the participant. These reports must accompany the provider service claim and are shared with the case manager. Case managers analyze the report and compare it with the authorized POS. Discrepancies are noted and acted on.

c. DHMH Federal Reporting (HCFA 372)

Annually DHMH must prepare a cost analysis of the waiver program, which documents the service cost and program's cost neutrality. The report is required six months after the end of a waiver year due to service providers having a nine-month billing timeline from delivery of service. Both the first and second years have demonstrated the program's cost neutrality.

d. Fiscal Audits

Fiscal staff audit service claim units with the Provider Service Report units authorized by the participant.

e. Case Management and Fiscal Intermediary Contracts Requirements

OPAS has recently procured a new contract for fiscal intermediary services and is evaluating proposals for case management services. Both services contracts require the vendors to monitor services utilization and report quarterly. The fiscal intermediary contractor specifically monitors consumer employed attendant care services. They are required to send a report to OPAS and the appropriate case management agency. Case management vendors will monitor and report on participant's services utilization based on their approved plan of service. Again, discrepancies will be noted and acted on.

Finding 5

Eligibility determinations for applicants to both waiver programs were not processed timely, and comprehensive plans of service were not received timely or properly completed.

Response:

We agree with the auditor's finding. The program has several Federal and State requirements and regulations with which to comply. Applicants must meet technical, financial, and medical criteria to be eligible and then enrolled in the program. DHMH, as the State Medicaid agency, has control over several entities involved in the eligibility process. DHMH has multiple divisions through which participants' applications, eligibility, and policy decisions are reviewed and processed. OPAS does have control and responsibility for internal processing within OPAS and case management services and will ensure authorization of all plans with a staff's signature. OPAS tracks and monitors applications through the various entities. In addition, OPAS recently began sending monthly inquiry letters to DHMH concerning the status of pending applications at their Division of Eligibility Waiver Services.

Delays can occur anywhere in the eligibility process and can be caused by flood of applicants (program demand), shortage of staff, applicant's schedule (e.g. ability to meet with AERS or Case Managers timely), applicants not providing financial documents timely, etc. In addition, the lack of accessible and affordable housing in the State has proved to be a significant barrier to the enrollment of nursing facility applicants. DHR and DHMH have made several policy and procedural changes to support a timely determination for applicants such as the elimination of primary care physician's signature on the medical assessment, streamlining the application process, and modifying internal processing procedures. DHR and DHMH have also requested exemptions to the hiring freeze to increase staff resources.

During the time this waiver program was implemented, the then Senior Assisted Housing Waiver was modified by legislation and federally approved to become the Older Adults Waiver. This waiver expansion severely impacted on the State's already limited resources within the various units involved with the application process resulting in lengthy delays in the eligibility determination process, e.g., timely notice of enrollment or denial.

To ensure timely eligibility determinations, additional staff is required at the DHMH's Division of Eligibility Waiver Services (DEWS) at a minimum. Staffing levels at the local Adult Evaluation and Review Services (AERS), DHMH Waiver Unit, and OPAS offices will also need to be re-examined and assessed for supplementation.

Eligibility Determination Process Entities and Steps (see Participant Application Process Flow Chart below)

DHMH's Adult Evaluation and Review Services (AERS), located in the local health departments, conducts medical assessments of all waiver applicants and recommends a community plan of care. After completing the assessment, AERS faxes a copy to the case manager and the Delmarva Foundation.

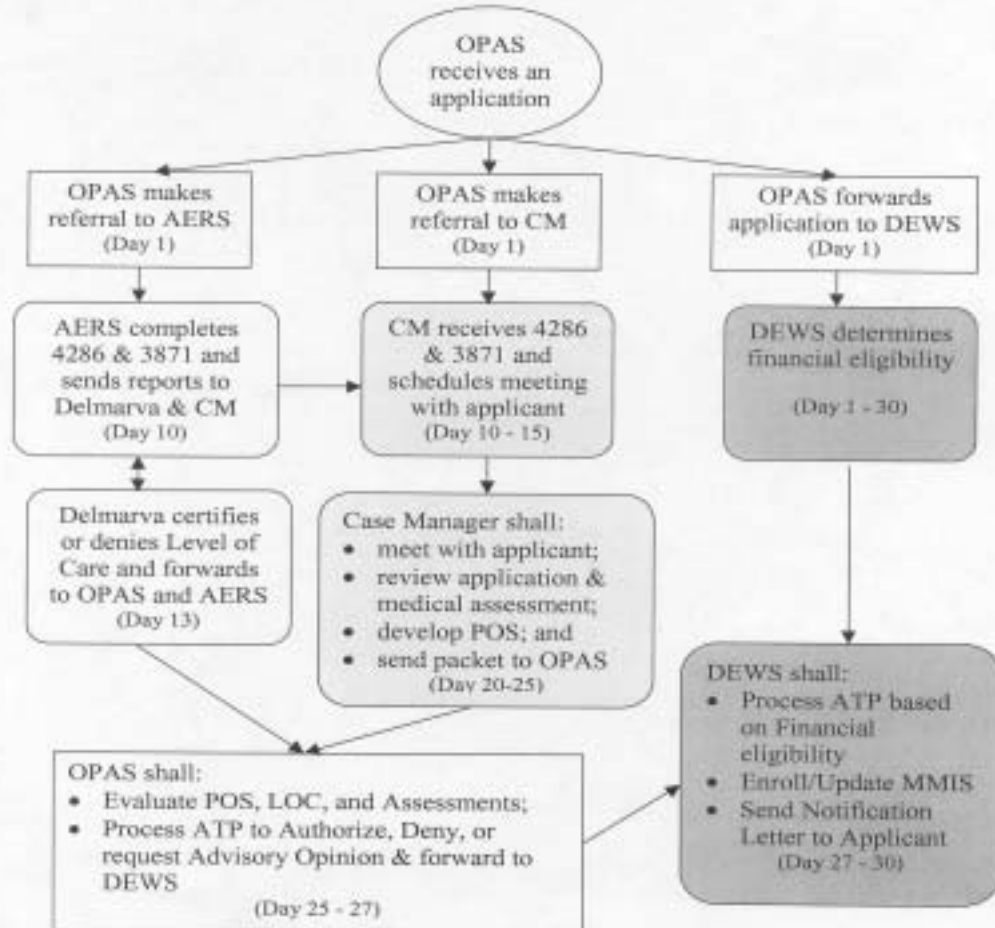
After receiving a copy of the AERS assessments, OPAS case management contractors are required to meet face to face with the applicant and develop a POS based on input from the applicant and the assessments. Once the case managers complete the POS, it is submitted to OPAS.

DHMH's contractor, the Delmarva Foundation determines whether the individual's medical condition meets the State's Nursing Facility Level of Care. Delmarva sends a letter noting their determination to OPAS.

OPAS staff reviews all documents and makes a recommendation, based on technical and medical eligibility, to authorize enrollment or denial of the applicant. OPAS recommendations are noted on an "Authorization to Participate" (ATP) form, which is submitted to DHMH's Division of Eligibility Waiver Services (DEWS).

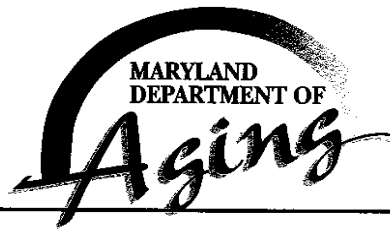
DHMH's DEWS determines Medicaid financial eligibility, authorizes MMIS waiver enrollment (if appropriate), and sends out a written enrollment or denial notice with appeal rights. The written notice is the official eligibility determination.

Living at Home: Maryland Community Choices Participant Application Process Flow Chart



Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor



Jean W. Roesser
Secretary

Jacqueline L. Phillips
Deputy Secretary

301 West Preston Street, Suite 1007 · Baltimore, Maryland 21201-2374
410-767-1100 · FAX 410-333-7943 · 1-800-AGE-DIAL · TTY users call via the Maryland Relay at 1-800-735-2258
www.mdoa.state.md.us

May 13, 2004

Bruce A. Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street, Room 1202
Baltimore, MD 21201

Dear Mr. Myers:

Enclosed is the Department of Aging's response to the April 2004 draft performance audit report on the Medicaid Waiver for Older Adults. An electronic copy of this response was sent to you on May 13, 2004.

As a result of the findings and recommendations of this audit, we have undertaken several improvements in the administration of the program. If you have any questions or require additional information, please do not hesitate to contact Warren Sraver, Manager of the Waiver for Older Adults program, at 410-767-1065.

Sincerely Yours,

A handwritten signature in dark ink, appearing to read "Jean Roesser".
Jean Roesser

Enclosure

C: Jacqueline Phillips
Jeffrey Myers
Ilene Rosenthal
Warren Sraver
Melissa Bartlett



CHOICE · INDEPENDENCE · DIGNITY

Maryland Department of Aging
Medicaid Waiver for Older Adults
Response to Performance Audit Report
May 2004

Finding 2

Case management services could be consolidated to improve cost efficiency.

Recommendation 2

We recommend that DHMH evaluate the responsibilities of the providers performing case monitoring services under the State Medicaid plan and the waiver programs and determine if a consolidation is practical to reduce State costs.

The Department of Health and Mental Hygiene will provide a response to this recommendation under separate cover.

Finding 3

Adequate supporting documentation was not required, and periodic audits were not conducted to verify the accuracy of certain provider claims paid for both waiver programs.

Recommendation 3

We recommend that DHR and DOA establish procedures to ensure that provider payments are appropriate and for legitimate purposes. For example, providers should be required to submit adequate documentation (such as recipient certification, timesheets) to support their claims for services provided to waiver recipients. We further recommend that periodic provider audits be conducted to ensure that services billed were actually provided. Finally, we recommend that appropriate corrective action be initiated as a result of current and future audits (recover overpayments, contact MFCU).

MDoA has taken several steps toward confirming the accuracy of billing claims submitted by waiver providers. Beginning June 1, 2004, all personal care providers will be required to attach completed timesheets to their billing claim forms. These time sheets must be signed and dated by the personal care aide or nurse monitor and the participant (or family member, as needed). It is expected to also match the number of hours listed in the participant's plan of care and the claim form, subject to random post claim verification. Claims will not be processed if the appropriate timesheet is not attached to the billing claims.

MDoA and DHMH are planning to convene provider trainings, beginning in June 2004, on a regular basis across the state, with a focus on billing accuracy and quality assurance issues.

To further promote the accuracy of timesheets, participant and family education efforts will be undertaken in the summer of 2004 that will stress not just an understanding of participants' rights under the waiver program, but will also more clearly identify participants' responsibilities to notify case managers promptly when services are not provided as called for in the plan of care and to report when any other service irregularities occur. Additionally, the outreach efforts will emphasize the importance of the role of participants and family members in certifying provider timesheets.

In June, MDoA will also begin sampling billings for accuracy in units and services provided. MDoA is working with DHMH on specifications for reports from MMIS II that can also be used to match services provided and paid for to those authorized in the participant's plan of care. MDoA will also conduct periodic on-site provider audits, in conjunction with case managers, to verify that waiver services paid for were actually provided. Discrepancies will be reported to the Medicaid Fraud Compliance Unit and other agencies for investigation, recovery actions and/or other sanctions.

MDoA has also met with the Attorney General's Medicaid Fraud Compliance Unit and the DHMH Corporate Compliance Unit in an effort to establish procedures and protocols to be followed to identify fraud when fraud is suspected. We have made arrangements for these units to train Area Agency on Aging staff later this year to improve their ability to spot fraud and how to follow up with their findings.

Finding 4

DHR and DOA were not effectively monitoring the hours of care provided or the “cost neutrality” of participant care.

Recommendation 4

We recommend that DOA and DHR establish procedures to monitor waiver recipient service utilization on a periodic basis (for example, quarterly) to ensure that appropriate services are provided and that recipients remain “cost neutral”. Specifically, we recommend that DOA and DHR reconcile waiver expenditure data from MMIS II with the respective plan of service. This monitoring should include verification to each plan of service to ensure that recipients received the proper number of hours of service and that services received were authorized.

Ensuring that services are actually provided to participants is one of the most important functions in the development of our quality assurance program. The issue reflects the continuing need for training of case managers, providers, and education of participants on the significance of the plan of care as it addresses cost neutrality and quality of care.

Monitoring of cost neutrality is an issue of major concern to case managers, as repeatedly expressed throughout our recent regional trainings. MDoA has been evaluating the monitoring of participants’ waiver service utilization for some time and has developed several courses of action to address the issue.

First, we are working with DHMH on the specifications for quarterly electronic reports from MMIS II that will detail all claims submitted for specific waiver participants. The information gleaned from MMIS II will be sorted according to AAA; this will allow distribution to the AAAs of pertinent billing information on their participants for comparison to plans of care. The goal is to evaluate at least 10% of all waiver participants each year. Discrepancies will be reported to MDoA for review and appropriate corrective action (provider sanctions, claim recovery, disenrollment of the provider, as needed).

The second element will be the implementation of an electronic tracking system that will allow case managers to closely monitor the enrollment process and electronically manage client information. Essential elements of the plans of care can be cited in the tracking system case notes section for review. The tracking system will thus help ensure the accuracy of plan of care information for billing staff and facilitate the quarterly MMIS samplings that case managers will be asked to review against the plans of care.

MDoA will also begin in June to identify a 10% sample of recipient plans of care and billing records for specific review; the sampling will include confirming that services are being provided as called for in the plan of care.

The analysis asserts that 7 recipients were provided more services than their specific plans of care outlined. It also refers to three recipients who were provided fewer units of service than their specific plans of care outlined. It is possible at certain times that a provider may be unable to remain with a participant for the required amount of time and an alternate cannot be found immediately, which will result in uneven hours of service provided. A family member or unpaid

caregiver may also be with a participant in lieu of the regular provider at certain times as a part of the back-up emergency portion of the POC. The program needs to have some degree of flexibility so it can respond to unscheduled events in a participant's life. The strategies we are putting in place will improve our ability to monitor these situations.

Finding 5

Eligibility determinations for applicants to both waiver programs were not processed timely, and comprehensive plans of service were not received timely or properly completed.

Recommendation 5

We recommend that DHR and DOA comply with State regulations and ensure that eligibility determinations are processed timely.

In 2003, DHMH awarded a contract to UMBC to develop an automated application tracking system for the Older Adults Waiver program. This web-based database allows authorized users to view at any time the status of an application and determine whether anything is delaying its processing. This will contribute substantially to a timelier enrollment process. The system was tested in two AAAs in the spring of 2004 and will be fully implemented statewide on June 1, 2004.

A second major initiative that is facilitating the timely processing of waiver applications is a policy change, effective April 1, 2004, that permits AAAs to act as MDoA's designee in reviewing and approving every waiver application, thereby removing one of the variables contributing to processing delays. As a part of its quality assurance efforts, MDoA will review a 10% sample of initial applications at each AAA to confirm that all necessary documentation has been acquired and maintained. The tracking system will also help with this effort as it includes alerts and other features designed to make sure that needed documentation is generated by various agencies involved in the enrollment process.

The third initiative in the improved processing of waiver applications is improving the quality and frequency of communications with case managers. MDoA held the first of a series of regional case manager trainings in March and April 2004, with a second training to be scheduled in the near future. The series will continue to emphasize the important elements of eligibility determinations, plan of care development, and other issues of concern to case managers.

Finding 6

Annual required eligibility redeterminations for the Older Adults Waiver recipients were not properly completed or processed timely.

Recommendation 6

We recommend that DOA ensure that all components of the annual eligibility redetermination process are adequately documented and properly completed within appropriate time frames.

The new Older Adults Waiver Application Tracking System has a feature that traces each element of the annual eligibility redetermination process. Authorized users will be able to determine when medical, financial, and technical redeterminations are due, whether anything is holding up their progress, and confirm whether a participant continues to be eligible for the waiver program as of the date of inquiry. Furthermore, the system will send automatic alerts to case managers and eligibility technicians whenever certain tasks are required and when actions have been taken by other persons involved in redetermining eligibility. DEWS will complete its forms electronically through the tracking system, enabling instant notification to case managers and MDoA.

The tracking system implementation will also relieve MDoA of the need to maintain a separate applicant and participant database, since eligibility information will now be electronically available to authorized agencies. Paper documentation will be kept primarily at the local level, to be examined by MDoA during quarterly performance audits of AAAs.

In addition, MDoA has requested that DHMH revise its Form OA5B to provide more useful information for participants and providers, thus eliminating the necessity for separate letters to be issued by MDoA that restate the cost of care information. DHMH is presently engaged in revising those forms.

The revised forms and new tracking system, combined with the discontinuation of the requirement that MDoA approve all key client documents, will now enable MDoA to devote its efforts toward improving turnaround time in the eligibility approval/disapproval process and ensuring quality improvement in services. Efforts to accelerate eligibility redeterminations will include regular training of case managers, ongoing systems analysis (in conjunction with DHMH), and regular contact with other agencies involved in the redetermination process.

Finding 7

Required criminal background checks were not always documented for personal care aides currently providing services to recipients of the Older Adults Waiver.

Recommendation 7

We recommend that DOA ensure that criminal background checks are obtained for all personal care providers participating in the Older Adults Waiver program.

There are currently 57 personal care agencies enrolled in the waiver program, some of which employ up to 600 aides. Combined with the more than 700 self-employed personal care aides approved for the waiver, there are currently over 3,000 aides whose criminal background reports are on file at MDoA, with new reports arriving each day. Due to this high number of aides, and the large amount of employee turnover, the maintenance of employee records on-site at MDoA has proven to be difficult to maintain at current staffing levels.

Therefore, MDoA has revised its protocol for ensuring that personal care agencies maintain necessary employee documents, including criminal background checks. Beginning June 1, 2004, personal care agencies are required to send monthly updated lists of waiver employees to MDoA. The administrative head of the agency or his or her designee will sign these monthly updates, which will certify that all required documentation for the employees on the list has been obtained and is available for review, including criminal background checks.

The MDoA staff member who maintains provider records will continue to obtain records for self-employed aides and, where warranted, will conduct on-site monitoring of personal care agencies to check for criminal background documents and all other required records. Efforts have been undertaken for several months to update MDoA's provider agency records, with one agency disenrolled from the waiver program (a decision under appeal) for improper recordkeeping.

These changes in protocol, in addition to provider training, will help ensure that criminal background checks are obtained and maintained on a current basis for all personal care providers participating in the waiver program.

Finding 8

DOA did not have adequate provider complaint resolution procedures.

Recommendation 8

We recommend that DOA establish formal procedures to investigate provider complaints, including a complaint log, which require the resolution of each complaint be properly documented. For complaints that result in irregularities, we further recommend that DOA refer legitimate complaints to the appropriate agencies (such as the Office of the Attorney General's Medicaid Fraud Control Unit) for further investigation. We further recommend that the provider previously identified by the AAA with billing irregularities be investigated and corrective action initiated, including referrals to the appropriate agencies, if the complaint is determined to be legitimate.

MDoA is working with DHMH to establish written procedures to be followed when complaints are received. There is a work group consisting of staff from both agencies, including staff from the Office of Health Care Quality (OHCQ), which has been developing procedures for handling complaints involving assisted living facilities. Additionally, a unit of OHCQ dedicated to Older Adults Waiver providers has been created to deal specifically with complaints related to licensees in the waiver program. Complaints involving other service providers are being addressed through policies and procedures developed by MDoA.

In response to the recommendations of this audit, MDoA now maintains a Waiver Complaint Log, which identifies the investigatory agencies that have been contacted regarding each complaint, and provides an organized method to ensure follow-up of each entry. The Complaint Log, in conjunction with written procedures and training of case managers and providers, will result in better management of complaints and improved documentation of complaint resolution.

MDoA has met with the Attorney General's Medicaid Fraud Control Unit and the Corporate Compliance Unit of DHMH to determine the role each agency has in investigating and resolving complaints involving Medicaid funds, and in training staff. The information gathered from those units will assist us in designing a workable and effective complaint resolution policy. These two units will also include our waiver and health insurance specialists in the trainings they are planning on fraud detection and intervention.

Additionally, the provider trainings being scheduled for early summer of 2004 will address the issue of what is considered fraudulent action by providers. The trainings will also clearly specify the range of sanctions that have been and will continue to be followed by DHMH and MDoA whenever a provider engages in improper billing practices.

In the situation identified in the discussion of findings, the Medicaid Fraud Control Unit declined to prosecute the case. As a result of this case, MDoA modified the procedures used to address billing complaints initiated by the AAAs and included the issue in the case manager trainings held in March and April 2004.

AUDIT TEAM

Richard K. Drain, CPA
Audit Manager

Heather A. Warriner
Senior Auditor

Nadine L. Forgenie
Nicholas R. Hollander
Staff Auditors

OTHER STAFF WHO CONTRIBUTED TO THIS REPORT

Albert E. Schmidt, CPA
Information Systems Senior Auditor